# **IPRS**

# Integrated Payment and Reporting System



# 837 Reporting Requirements

Version 1.15

November 2006

#### The 837 Transaction Set

The ANSI X12N 837 transaction set is used to report claims to MMIS+. The same transaction set is used to report both Medicaid and DMH/DD/SA claims. MMIS+ routes the each claim to the appropriate financial payer, based on eligibility and service information reported on the claim. This file is transmitted electronically to IPRS by the Local System Administrator.

All Medicaid and DMH/DD/SA claims must be reported using the 837 transaction set EXCEPT:

• Medicaid claims with third party liability attachments

When reporting to MMIS+ using the 837:

- Client ID can be Medicaid ID, or any ID cross-referenced to that ID in CNDS/IPRS.
- ICD 9 primary diagnosis required. Additional diagnoses can be reported if applicable.
- Decimal quantity units of service are accepted by IPRS. An hourly service can be submitted as 1.5 for 1 hour, 30 minutes.

#### Three providers must be reported on the claim:

- **Billing provider** files claims and receives payments, used to route claim to best financial payer.
- Attending provider agency / program that renders service, used to determine the best population group.
- Referring provider Responsible LMA, whose budget will pay for the service

# **Claims Filing - Overview of User Tasks**

The Integrated Payment and Reporting System (IPRS) is a claims processing system that will pay Division of MH/DD/SA (DMH) funds for claims submitted by billing providers enrolled in IPRS. The IPRS replaces volume of service reporting for Pioneer, At-Risk Children and MRMI UCR systems. The Medicaid Management Information System (MMIS) is a claims processing system that pays Division of Medical Assistance (DMA) funds for claims submitted by billing providers enrolled in MMIS. IPRS together with the MMIS comprise the MMIS+.

Area programs are enrolled as billing providers in both IPRS and MMIS. Claims are sent by area programs to the MMIS+ in the same format for both IPRS and MMIS. The MMIS+ system determines the 'best payer' based on information on the claim.

EDS is the fiscal agent that operates the MMIS+. Claims are submitted to EDS for processing.

Below is the process used to submit claims to MMIS+:

#### Enter billable activity into local client accounting system.

Each billing provider enters records of services provided in their local client accounting system. The local client accounting system stores the service activity records, and submits billable activities to 'Payers'. Medicaid and DMH are designated as payers in the local client accounting systems.

New claims are submitted to MMIS+ in an electronic format.

The local client accounting system stores and submits a group (batch) of claims. For MMIS+, claims are submitted in an Electronic Format that is compliant with a national standard called ANSI X12N 837. This is the standard required by HIPAA. The client accounting system generates a file in the 837 format, and the computer administrator transmits that file to an EDS electronic mailbox. Claims can be submitted daily.

#### Review the Electronic Acknowledgement for files submitted electronically.

After an 837 file is transmitted to the EDS mailbox, two files will be generated to acknowledge the receipt of the transactions and report certain types of problems in the transaction set. These files should be reviewed by the sender and are called 997 functional acknowledgement and U277 unsolicited response.

#### Adjustment claims, and Medicaid claims with Third Party Liability, are mailed to EDS.

Certain types of claim activity must be done using hard copy claims and attachments. This includes adjustment claims, and Medicaid claims when the recipient has other third party coverage. This will need to be changed. See Linda

#### On Fridays, the MMIS+ performs claims payment processing (a "Checkwrite cycle").

Generally, checkwrite cycles are run the 1<sup>st</sup>, 2<sup>nd</sup> and 3<sup>rd</sup> Fridays of each month. A schedule is published annually and distributed to billing providers. Claims that were submitted since the previous checkwrite cycle are routed to the best payer, assigned an Internal Claim Number (ICN) and processed. Some claims that were partially processed during previous cycles may also be re-processed, such as suspended claims, deny-re-enter claims, and system generated claims for retroactive Medicaid eligibility or retroactive rate revisions.

# Filing a Claim

Using the ASC X12N 837 – Health Care Claim for Professional Claims transaction set, claims are submitted electronically for both Medicaid and IPRS to the North Carolina MMIS+. Electronic claims submission offers the provider a low cost, highly reliable alternative to paper claim submission. No paper claims will be accepted, except Medicaid claims with Third-Party Liability and adjustments.

Note @

Only claims received from IPRS enrolled billing providers will be processed in IPRS.

# Steps to Begin Electronic Billing

#### 1. Establish a TPA with Electronic Data Systems

The TPA is a legal document that identifies the EDI partners, transaction sets, usage of data requirements, and file specifications. The TPA has already been completed for billing providers during the pilot site implementation. Permanent procedures will be implemented once fiscal agent services are established.

#### 2. Notify Software Vendor

- Billing electronically requires software capable of connecting to the EDS Bulletin Board (electronic mailbox).
- Instruct your software vendor to write a program using specifications outlined in the TPA for data requirements of the ASC X12N 837 – Health Care Claim for Professional Claims transaction set

#### 3. Signature Requirements

Since it is not possible for the provider to sign claims submitted electronically, the provider must sign and return an Electronic Claims Submission Agreement prior to the submission of claims. The agreement will be retained by the DMA and DMH to serve in lieu of the provider's signature for each claim submitted electronically. To obtain this form, contact EDS.

Upon receipt of the ECS agreement, sign and return all copies to:

Division of Medical Assistance DMH/DD/SA 1985 Umstead Drive Data Operations

Raleigh, NC 27603 3019 Mail Service Center Attn: Recipient & Provider Services Raleigh, NC 27699-3019

DMA and DMH will retain one copy of the agreement and return one copy to the provider.

#### 4. Authorization Numbers

Upon receipt of an approved TPA and ECS agreement, the provider will contact EDS to have a logon authorization number and password assigned. Once assigned, the Logon Authorization Number will be made active for testing only. The logon authorization number is initially set up as TEST in order to verify data accuracy and to ensure successful data transmissions. No electronic claims will be paid until testing is complete.

#### 5. Testing Requirements for new IPRS Providers

Before electronic claims can be processed for payment, testing of claims submission procedures must be successfully completed. Test claims will be checked thoroughly to verify compliance with file specifications.

Submit between 5 to 20 claims for a TEST. These claims can be previously paid claims, or new claims to be submitted for payment at a later date. Claims must have valid information (i.e., valid recipient identification numbers, provider number(s), diagnosis, procedure codes, etc) and dates of service must not be over one year old. Claims will be tested to make sure the billing information and formats are correct.

After your claims are received, the EDS Testing Coordinator will process the transmission and determine the appropriate action to take. Testing may require one or more submissions depending on the severity of formatting and data errors. The EDS Testing Coordinator will contact providers with test results within 5 to 7 business days. After successful completion of testing, the logon authorization number and password will be activated for production. From this point forward all claims processed will be paid according to the policies of DMH/DD/SA Services. No payment will be made on test claims. After testing is complete, the provider is responsible for resubmitting the claims used during testing in order for the claims to be processed for payment.

### **Special Considerations**

Changes to software or hardware after claim submission has begun may result in unexpected results. If a change occurs in your system, contact EDS and request a testing logon authorization number.

#### Helpful Hints for Testing

During testing, providers often fail on their first attempt for various reasons. Listed below are helpful hints for successful testing:

- Learn and understand how to bill IPRS ANSI X12N 837, (see both the HIPAA Implementation Guide and the IPRS Layout section of this requirements document).
- Do not include dashes or place spaces within the recipient's Medicaid or IPRS identification number.
- Do not include decimal points or place spaces with the diagnosis code(s).

#### Hours of Operation for Filing Claims

EDS receives claims submitted electronically via an Electronic File Transfer Process. Claims may be submitted 7 days a week 24 hours a day. Only claims received by the EDI translator by 5:00 PM on Fridays will be processed by that week's checkwrite cycle.

#### Multi-detail vs. Single-detail

IPRS accepts health insurance claims for professional services. Before MMIS+ and IPRS, these claims were filed using the HCFA 1500 format. Claims are now filed using the ANSI X12N 837 professional claim format. A claim filed by a billing provider for a recipient can contain more than one service level detail line. For example, Duplin Sampson (billing provider) can submit a claim for John Doe (recipient) who received one service event on March 1<sup>st</sup> and another service event on March 8<sup>th</sup>. If both service events are filed on the same claim, this is a multi-detail claim. On the 837, for the same "subscriber" (recipient), more than one LX and SV segment is contained with the same 2000B loop.

It is strongly recommended that claims be filed as single-detail claims. For the example above, the Loop 2300 – Claim Information (CLM) segment should be repeated for each separate LX, SV segment. For single-detail claims, LX should always be followed by a '1'.

#### Multi-detail Claims Problems

If multi-detail claims are submitted, the following problems occur during claims processing:

- One detail of a multi-detail claim cannot suspend when another detail pays or denies. All
  details of a multi-detail claim will be adjudicated to pay or deny.
- Financial processing of adjustments for multi-detail claims is more complex, resulting in unprocessed adjustments for some claims.
- Retroactive Medicaid adjustments will have to be filed manually for multi-detail claims.
- All details of claim will process using the Header level Referring and Rendering Provider information, even if submitted specific to the detail.

# 837 Transaction Set Header/Trailer and 997 Transaction Set/Functional Group Response Trailer

The 837 Transaction Set Header (ST Segment) indicates the start of a transaction. The 837 Transaction Set Trailer (SE Segment) indicates the end of the transaction set and provides a count of the transmitted segments (including the beginning (ST) and ending (SE) segment). The 997 Transaction Set Response Trailer (AK5 Segment) is used to acknowledge acceptance or rejection and report errors in a transaction set. The 997 Functional Group Response Trailer (AK9 Segment) is used to acknowledge acceptance or rejection of a functional group and report the number of included transaction sets from the original trailer, the accepted set, and the received sets in the functional group. This simply means that for every ST/SE segment in the 837 transaction set, there is a corresponding AK5 segment in the 997 and for every transmission there is an AK9 segment in the 997 transaction set. In order to validate the status of each claim using the 997, every claim submitted by the billing provider must begin with an ST segment and end with an SE segment. This results in multiple ST/SE segments in one transaction. The billing provider can use the 997 to easily identify that the claim was accepted by the system for processing. See the following example.

#### Example:

3 claims are transmitted via 837 transaction set. There are ST/SE segment for claims 1 and 2. Claim 3 has an ST segment, but is missing an SE segment. Using the 997, the billing provider receives an AK5 for each ST segment. The AK9 line as highlighted below informs the billing provider that the transaction is partially accepted (P). The first 3 indicates there were 3 claims in the transaction. The next 3 indicates there were 3 total claims. The 2 indicates that only 2 claims were accepted. The 4 in the AK9 defines the type of error in the 837 transaction. In this particular example, the error is the result of a missing SE segment for claim 3 in the 837 transaction. (Please refer to the 997 Functional Acknowledgment section of the 837 Implementation Guide for additional information about the 997.)

<u>837</u>	<u>997</u>
ST*837*12345~	ST*997*98765~
~	AK2*837*12345~
Claim 1 Header~	AK5*A~
Claim 1 Detail~	AK2*837*23456~
~	AK5*A~
SE*1*12345~	AK2*837*34567~
ST*837*23456~	AK5*A~
~	AK9*P*3*3*2*4~
Claim 2 Header~	SE*9*98765~
Claim 2 Detail~	
~	
SE*1*23456~	
ST*837*34567~	
~	
Claim 3 Header~	
Claim 3 Detail~	
<b>~</b>	

### **Claims Filing Required Fields-Procedure Codes**

#### **Procedure Codes**

Whenever possible, standard procedure codes are used in MMIS and IPRS. When a procedure code is valid in both IPRS and MMIS, claim will be routed to the best payer based on client eligibility and provider enrollment. However, IPRS also includes procedure codes that are not valid in MMIS. These procedure codes are for services that are covered by DMH benefit plans, but not by Medicaid. Examples are Consultation, Education and Primary Prevention (YP110), Case Support (YP220), and Residential Supports (YM850).

Procedure codes have been assigned using the following guidelines:

- Whenever possible, national standard HCPCS codes have been used. These codes are five digit numbers that begin with '9'. The unit of service for many of the HCPCS codes is one unit for one event. However, some HPCPS codes use 15 minute or daily units. In general, these codes are valid for both IPRS and MMIS.
- Codes previously used in the Pioneer UCR are the Pioneer service code, preceded with a 'YP'. The units of service for these codes are 15 minute units for periodic and day treatment/activity, and day units for residential. These codes are not valid for MMIS.
- Codes previously used in the MRMI (Thomas S.) UCR are the MRMI service code, preceded with a 'YM'. The units of service for these codes are 15 minute units for periodic and day treatment/activity, and day units for residential. These codes are not valid for MMIS.
- Codes previously used in the CTSP (ARC) UCR are the CTSP service code, preceded with a
  'YA'. The units of service for these codes are 15 minute units for periodic and day
  treatment/activity, and day units for residential. These codes are not valid for MMIS.

It is important to understand that each population group has a benefit plan that covers a defined set of procedures. If a procedure is not covered by the benefit plan for a population group, the claim will be routed to a different population group that covers the service (if the client and provider are eligible in more than one population group.) If there is not a match between a client's eligibility, a provider's eligibility and a procedure covered by a benefit plan, the claim will deny.

## **The 837 Transaction Set**

# **Definition of Required Fields for the 837 Transaction Set**

# Required Fields: 837 Transaction Summary

Loop/Segment	Comment	
TRANSMISSION HEADER		
ISA Interchange Control Header	Repeat 1 time per transaction set	
GS Functional Group Header		
ST TRANSACTION SET HEADER	Repeat for each different transaction set in the transmission.	
BHT Beginning of Hierarchical Transaction		
Transmission Type Identification		
Loop 1000A - Submitter Name		
Submitter EDI Contact Information		
Loop 1000B - Receiver Name		
	BILLING PROVIDER	
Loop 2000A Billing/Pay-To Provider Hierarchical Level	Repeat for each different billing provider in the 837 transaction set (ST), incrementing HL count for each additional billing provider.	
Billing/Pay-To Provider Specialty Information		
Loop 2010AA - Billing Provider Name		
Billing Provider Address		
Billing Provider City/State/Zip Code		
Billing Provider Secondary Identification		
	SUBSCRIBER	
Loop 2000B - Subscriber Hierarchical Level	Repeat for each different client within the billing provider in LOOP 2000A, incrementing HL count for each additional client within the billing provider.	
Subscriber Information		
Loop 2010BA - Subscriber Name		

Loop/Segment	Comment
Subscriber Street	Comment
Subscriber City/State/Zip Code	-
Demographic Information	
Loop 2010BB - Payer Name	_
Loop 2010BB - 1 ayer Name	
	CLAIM
Loop 2300 - Claim Information	Repeat for each claim for client in LOOP 2000B
Date Initial Treatment (Situational)	SITUATIONAL – Not required for IPRS, Required for Medicaid when reporting Specialized Therapies.
Date Accident (Situational)	
Claim Supplemental Information (Situational)	SITUATIONAL – Not required for IPRS, Required for Medicaid F2 Stamp usage
Claim Reference (Situational)	SITUATIONAL – Required when submitting Replacement or Void Transactions
Medicaid Record Information	
Health Care Diagnosis Code	
Loop 2310A – Referring Provider Name	
Referring Provider Specialty Information	
Referring Provider Secondary Information	
Loop 2310B - Rendering Provider Name	SITUATIONAL LOOP – Required when Rendering Provider is different from Billing Provider.
Rendering Provider Specialty Information	
Rendering Provider Secondary Information	
Loop 2310D – Service Facility Location	
Service Facility Location Street	
Service Facility Location City/State/Zip Code	
Service Facility Location Secondary Identification	
Loop 2320 - Other Subscriber Information (Situational)	SITUATIONAL LOOP - Not required for IPRS, Required by Medicaid when reporting TPL.
Payer Paid Amount	
Subscriber Demographic Information	
Other Insurance Coverage Information	
Loop 2330A - Other Subscriber Name	SITUATIONAL LOOP - Not required for IPRS, Required by Medicaid when reporting TPL.
Loop 2330B - Other Payer Name	SITUATIONAL LOOP - Not required for IPRS, Required by Medicaid when reporting TPL.
Date Paid	
Paid Claim Number	

Loop/Segment	Comment			
	SERVICE DETAIL			
Loop 2400 – Service Line	Repeat for each service detail line for the claim LOOP 2300.			
Professional Service				
Service Date				
Line Item Control Number				
Loop 2420A - Rendering Provider Number	SITUATIONAL LOOP – Required when Rendering Provider is different from Header Level Rendering Provider. NOTE: Data is information only at this level. Claims processing will occur using the header level information only.			
Rendering Provider Specialty Information				
Rendering Provider Secondary Identification				
Loop 2420F - Referring Provider Number	SITUATIONAL LOOP – Required when Referring Provider is different from Header Level Referring Provider. NOTE: Data is information only at this level. Claims processing will occur using the header level information only.			
Referring Provider Specialty Information				
Referring Provider Secondary Identification				
Loop 2430 - Service Line Adjudication (Situational)	SITUATIONAL LOOP- Not Required by IPRS, Required by Medicaid when reporting TPL for the detail line			
Line Adjustment Information (Situational)	SITUATIONAL- Not Required by IPRS, Required by Medicaid when reporting TPL where the paid amount was different from the original billed amount			
Date Paid (Situational)	SITUATIONAL- Not Required by IPRS, Required by Medicaid when reporting TPL			
TRANSACTION TRAILER				
Transaction Set Trailer	Must match ST			
Functional Group Trailer	Must match GT and ISA			
Interchange Control Trailer				

# 837 Transaction Layout

HIPAA FIELD -	HIPAA FIEL	LD NAME	FIELD LENGTH	DATA CONTENT	COMMENT		
PAGE#							
- NITEDOLIA	INTERCHANGE CONTROL HEADER Occurs 1 time Required						
			Occurs 1		Required		
ISA		Control Header	8	ISA	HIPAA Requirement		
ISA01		n Information Qualifier.	2/2	00 - No Authorization Info Present	HIPAA Requirement		
ISA02		n Information	10/10		Optional		
ISA03		ormation. Qualifier	2/2	00 - No Security Info Present	HIPAA Requirement		
ISA04	Security Info		10/10		Optional		
ISA05		ID Qualifier	2/2	ZZ - Mutually Defined Id for Sender in ISA06	HIPAA Requirement		
ISA06	Interchange	Sender ID.	15/15	Sender ID = Number from Trading Partner Agreement	HIPAA Requirement		
ISA07	Interchange	ID Qualifier	2/2	ZZ - Mutually Defined Id for Sender in ISA08	HIPAA Requirement		
ISA08	Interchange	Receiver ID	15/15	DNC00	HIPAA Requirement		
ISA09	Interchange	Date	6/6	Date of the Interchange in YYMMDD format	HIPAA Requirement		
ISA10	Interchange	Time	4/4	Time of the Interchange in HHMM format	HIPAA Requirement		
ISA11	Interchange Identification	· Control Standard n	1/1	U - US EDI Community of ANSI X12 standards	HIPAA Requirement		
ISA12	Interchange	Control Version Number	5/5	00401 - Version of above Standards	HIPAA Requirement		
ISA13	Interchange	Control Number	9/9	00000001 – Number assigned by sender. Must = the number in IEA02	HIPAA Requirement		
ISA14	Acknowledg	ment Requested	1/1	1 - Code requesting an acknowledgement record	HIPAA Requirement		
ISA15	Usage Indic		1/1	T - Test Data P- Production Data	HIPAA Requirement		
ISA16	Component	Element Separator	1/1	Delimiter used to separate component elements	HIPAA Requirement		
Example Se	gment ISA*00*	*00* *ZZ*12345678	9 *ZZ*DN	VC00 *000901*1705*U*00401*00000001*1*T*:~			
	AL GROUP HEA	ADER	Occurs 1		Required		
GS		Functional Group Header	2/2	GS	HIPAA Requirement		
GS01		Functional Id Code	2/2	HC – Health Care Claim	HIPAA Requirement		
GS02 Application Senders Code		15/15	Same number as ISA06 - Identifies the Sender	HIPAA Requirement			
GS03 Application Receivers Code		15/15	Same number as ISA08 - Identifies the Receiver	HIPAA Requirement			
GS04 Date		8/8	CCYYMMDD - Group date	HIPAA Requirement			
GS05	GS05 Time		4/8	HHMM - Group time	HIPAA Requirement		
GS06 Group Control Number		1/9	Control number from sender	HIPAA Requirement			
GS07 Responsible Agency Code		1/2	X – Accredited Standards Committee	HIPAA Requirement			

HIPAA FIELD - PAGE#	HIPAA FIELD NAME	FIELD LENGTH	DATA CONTENT	COMMENT
GS08	Version/Release ID Code	1/12	004010X098A1 - Version of above Standards	HIPAA Requirement
	nent GS*BE*123456789*DNC00*2000090			Tim 70 Creaquiromone
TRANSACTION SET HEADER		Occurs 1		Required
ST01 - p62	Transaction Set ID Code	3/3	837	HIPAA Requirement
ST02 - p62	Transaction Control no.	4/9	Unique no. assigned to transaction set. ST02 and SE02 must be identical.	HIPAA Requirement
Example: ST*	837*918273645~	<b>I</b>		1
	OF HIERARCHICAL TRANSACTION	Occurs 1	time	Required
BHT01 - p63	Hierarchical Structure Code	4/4	0019 - Information Source, Subscriber, Dependent	HIPAA Requirement
BHT02 - p64	Transaction Set Purpose Code	2/2	00 – Original	HIPAA Requirement
BHT03 - p64	Reference Identification	1/30	The number assigned by the originator to identify the transaction within the originator's business application system.	HIPAA Requirement
BHT04 - p64	Date	8/8	Enter date in CCYYMMDD format.	HIPAA Requirement
BHT05 - p65	Time	4/8	Enter time in HHMM format.	HIPAA Requirement
BHT06 - p65	Transaction Type Code	2/2	CH – Chargeable	HIPAA Requirement
Example: BH7	Г*0019*00*01234*20001006*1000*СН~			
	Type Identification		Occurs 1 time	
REF01 - p66		2/3	87 – Functional Category	HIPAA Requirement
REF02 - p66	Reference Identification	1/30	004010X098A1.	HIPAA Requirement
	F*87*004010X098A1~			
	- SUBMITTER NAME	Occurs 1		Required
Submitter Na			Occurs 1 time per Loop 1000A occurrence	
NM101 - p68	Entity Identifier Code	2/3	41 – Submitter	HIPAA Requirement
NM102 - p68	Entity Type Qualifier	1/1	2 – Non-Person Entity	HIPAA Requirement
NM103 - p68	Name Last or Org. Name	1/35	Org Name of Submitter	HIPAA Requirement
NM104 - p68	Not Used		Not Used	Optional
NM105	Not Used		Not used	Optional
NM106	Not Used		Not used	Optional
NM107	Not Used		Not used	Optional
NM108 - p68	Identification Code Identifier	1/2	46 - Electronic Transmitter Identification Number (ETIN) Established by Trading Partner Agreement	HIPAA Requirement
NM109 - p69	Identification Code	2/80	Submitter Identifier Number – This is the mailbox ID. It is assigned by EDS and included in the TPA. The mailbox ID is used to validate the submitter in order	Required and Edited

HIPAA	HIPAA FIELD NAME	FIELD	DATA CONTENT	COMMENT
FIELD -		LENGTH		
PAGE#				
		T		
			to perform EDI transactions.	
	*41*2*DUPLIN/SAMPSON****46*MAILBOX			
	Contact Information		to 2 times per Loop 1000A occurrence	Required
PER01 - p72	Contact Function Code	2/2	IC – Information Contact	HIPAA Requirement
PER02 - p72	Name	1/60	Enter submitter's contact name.	HIPAA Requirement
PER03 - p72	Communication Number Qualifier	2/2	TE – Telephone	HIPAA Requirement
PER04 - p72	Communication Number	1/80	Phone number of the contact, including area code.	HIPAA Requirement
	*IC*JAMIE SMITH*TE*9105555555~			_
	RECEIVER NAME	Occurs 11		
Receiver Name			time per Loop 1000B occurrence	Required
NM101 - p75	Entity Identifier Code	2/3	40 – Receiver	HIPAA Requirement
NM102 - p75	Entity Type Qualifier	1/1	2 - Non-Person Entity	HIPAA Requirement
NM103 - p75	Name Last or Org. Name	1/35	EDS	HIPAA Requirement
NM104	Not Used		Not used	Optional
NM105	Not Used		Not used	Optional
NM106	Not Used		Not used	Optional
NM107	Not Used		Not used	Optional
NM108 - p75	Identification Code Qualifier	2/80	46	HIPAA Requirement
NM109 - p75	Identification Code	2/80	DNC00	HIPAA Requirement
Example: NM1*	*40*2*EDS****46*DNC00~			
HIERARCHICA		Occurs as	many times as needed	
Billing/Pay-to	Provider Hierarchical Level		time per Loop 2000A occurrence	Required
HL01 - p78	Hierarchical ID Number	1/12	Must begin with ""1"" and be incremented by one each time an HL is used in transaction.	Required and Edited
HL02	Not Used		Not used	Optional
HL03 - p78	Hierarchical Level Code	1/2	20 – Information Source	HIPAA Requirement
HL04 - p78	Hierarchical Child Code	1/1	1 – Additional Subordinate HL Data Segment in this Hierarchical Structure	HIPAA Requirement
Example: HL*1	**20*1~			

HIPAA FIELD - PAGE#	HIPAA FIELD NAME	FIELD LENGTH	DATA CONTENT	COMMENT
Billing/Pay-To Provider Specialty Information		Occurs 1	Occurs 1 time per Loop 2000A occurrence	
PRV01 - p79	Provider Code	1/3	BI – Billing	HIPAA Requirement
PRV02 - p80	Reference Identification Qualifier	2/3	ZZ – Mutually Defined Health Care Provider Taxonomy Code List	HIPAA Requirement
PRV03 - p80	Reference Identification	1/30	Provider Taxonomy Code -10 digit taxonomy code for the billing provider.  Taxonomy must comply with HIPAA.  **NOTE – Taxonomy codes are updated on a periodic basis. If submitted, this value will need to be maintained to remain compliant.	HIPAA Requirement
Example: PRV	/*BI*ZZ*261QM1300X~			
	A - BILLING PROVIDER NAME		time per Loop 2000A Occurrence	
<b>Billing Provid</b>	er Name	Occurs 1	time per Loop 2010AA occurrence	Required
NM101 - p85	Entity Identifier Code	2/3	85 – Indicates billing provider	HIPAA Requirement
NM102 - p85	Entity Type Qualifier	1/1	2 – Non-Person	HIPAA Requirement
NM103 - p85	Name Last or Org Name	1/35	Enter billing provider's name. The billing provider's name is mapped into the MMIS+ and IPRS but truncated to 5 bytes	Required and Edited
NM104 - p85	Not Used		Not Used	Optional
NM105	Not Used		Not Used	Optional
NM106	Not Used		Not Used	Optional
NM107	Not Used		Not Used	Optional
NM108 - p86	Identification Code Qualifier	1/2	24 – Employer's Identification Number if provider is atypical XX – NPI if provider is typical	HIPAA Requirement
NM109 - p86	Identification Code	2/80	Federal Tax Number (atypical)  OR NPI Number (typical)	HIPAA Requirement

HIPAA FIELD - PAGE#	HIPAA FIELD NAME	FIELD LENGTH	DATA CONTENT	COMMENT				
	Examples: NM1*85*2*DUPLIN/SAMPSON BILLER*****24*12345678~  NM1*85*2*WAKE LME*****XX*1234567893~							
Billing Provide		Occurs 1	time per Loop 2010AA occurrence	Required				
N301 - p88	Address Information	1/55	Billing provider's address. Note: This is not a means for updating provider information. Use provider enrollment process.	HIPAA Requirement				
Example: N3*1	23 HELPFUL STREET~	-						
	er City/State/Zip Code		time per Loop 2010AA occurrence	Required				
N401 - p89	City Name	2/30	Billing provider's city name.	HIPAA Requirement				
N402 - p90	State or Province Code	2/2	Billing provider's state code.	HIPAA Requirement				
	Postal Code	3/15	Billing provider's zip code including 4-digit extension.	HIPAA Requirement				
	OUPLIN/SAMPSON*NC*23110 <mark>1234</mark> ~							
	er Secondary Identification		time per Loop 2010AA occurrence	Required by IPRS if Referring Provider is atypical, i.e. NM108 contains 24				
REF01 - p92	Reference Identification Qualifier	2/3	0B – State License Number (atypical) 1D – Medicaid Provider Number (atypical) EI – Employer's Identification Number SY – SSN (when the provider is typical – XX in NM108 – at least one REF must be submitted with either the EIN or SSN of the billing provider)	HIPAA Requirement				
REF02 - p92	Reference Identification	1/30	Enter billing provider's number. The billing provider's number is mapped into the MMIS+ and IPRS	Required and Edited				
REF	<sup>-</sup> *0B*3404045~ <mark>-*SY*123456789~</mark>							
LOOP 2000B - SUBSCRIBER HIERARCHICAL LEVEL		Occurs as many times as needed						
	erarchical Level	Occurs 1 time per Loop 2000B occurrence		Required				
HL01 - p109	Hierarchical ID Number	1/12	Number assigned by the sender to each HL segment within the transmission.	HIPAA Requirement				
HL02 - p109	Hierarchical Parent ID Number	1/12	Number of next hierarchical data segment that the data segment being described is subordinate to.	HIPAA Requirement				
HL03 - p109	Hierarchical Level Code	1/2	22 – Subscriber	HIPAA Requirement				

HIPAA FIELD - PAGE#	HIPAA FIELD NAME	FIELD LENGTH	DATA CONTENT	COMMENT
	<del>_</del>	-		
HL04 - p109	Hierarchical Child Code	1/1	0 – No Subordinate HL segment in this hierarchical structure	HIPAA Requirement
Example: HL*				
Subscriber In	nformation	Occurs 1	time per Loop 2000B occurrence	Required
SBR01 - p110	Payer Responsibility Sequence Number Code	1/1	P – Primary	HIPAA Requirement
SBR02 - p111	Individual Relationship Code	2/2	18 – Self	HIPAA Requirement
SBR03	Not Used		Not Used	Optional
SBR04	Not Used		Not Used	Optional
SBR05	Not Used		Not Used	Optional
SBR06	Not Used		Not Used	Optional
SBR07	Not Used		Not Used	Optional
SBR08	Not Used		Not Used	Optional
SBR09 - p112	Claim Filing Indicator Code	1/2	MC - Medicaid	HIPAA Requirement
Example: SBF	R*P*18******MC~	•		
	A - SUBSCRIBER NAME	Occurs 1	time per Loop 2000B occurrence	
Subscriber N	ame		time per Loop 2010BA occurrence	Required
NM101 - p118	Entity Identifier Code	2/3	IL – Insured or Subscriber	HIPAA Requirement
NM102 - p118	Entity Type Qualifier	1/1	1 – Person	HIPAA Requirement
NM103 - p118	Name Last or Org Name	1/35	Last name of client. Last name must match CNDS name. The last name (truncated to 5) is mapped into the MMIS+ and IPRS.	Required and Edited
NM104 - p118	Name First	1/25	First name of subscriber (patient). Required if NM102=1. Note: Only 1st initial of first name is mapped.	Required and Edited
NM105 - p118	Not Used		Not used	Optional
NM106 - p118	Not Used		Not used	Optional
NM107 - p118	Not Used		Not used	Optional

HIPAA FIELD - PAGE#	HIPAA FIELD NAME	FIELD LENGTH	DATA CONTENT	COMMENT	
NM108 - p119	Identification Code Qualifier	1/2	MI – Member Identification Number	Required and Edited	
NM109 - p119	*IL*1*SMITH*JANE****MI*912478911A~	2/80	Enter patient's ten-digit Medicaid or IPRS Client ID.  IPRS Client ID can be up to 11 digits.  LMA's local ID (Facility code + client record number) may be submitted and will be cross-referenced for processing in the IPRS.  MR/MI and CTSP may submit their unique ID if cross-referenced.  The patient Medicaid or IPRS client ID is mapped into the MMIS+ and IPRS.	Required and Edited	
			time per Loop 2010BA occurrence	Required	
N301 - p121	Address Information	1/55	Subscriber Address	HIPAA Requirement	
	456 INNEED STREET~				
	ity/State/Zip Code	Occurs 1	time per Loop 2010BA occurrence	Required	
N401 - p122	City Name	2/30	Subscriber City Name	HIPAA Requirement	
N402 - p123	State or Province Code	2/2	Subscriber State Code	HIPAA Requirement	
N403 - p123	Postal Code	3/15	Subscriber Postal Code	HIPAA Requirement	
Example: N4*\	WARSAW*NC*27412~			•	
Demographic			time per Loop 2010BA occurrence	Required	
DMG01 - p124	Date Time Period Format Qualifier	2/3	D8 – Date expressed in format CCYYMMDD.	HIPAA Requirement	
DMG02 - p125	Date Time Period	1/35	Subscriber DOB.	Required and Edited	
DMG03 - p125	Gender Code	1/1	F – Female M – Male U – Unknown	HIPAA Requirement	
Example: DMG*D8*19770615*F~					
	B - PAYER NAME		time per Loop 2000B occurrence	Required	
Payer Name		Occurs 1	Occurs 1 time per Loop 2010BB occurrence		

HIPAA FIELD - PAGE#	HIPAA FIELD NAME	FIELD LENGTH	DATA CONTENT	COMMENT
NM101 -	Entity Identifier Code	2/3	PR – Payer	HIPAA Requirement
p131				'
NM102 - p131	Entity Type Qualifier	1/1	2 – Non-Person Entity	HIPAA Requirement
NM103 - p131	Name Last or Org Name	1/35	EDS/NC DHHS  Covers both DMA and DMH/DD/SA	HIPAA Requirement
NM104	Not Used		Not used	Optional
NM105	Not Used		Not used	Optional
NM106	Not Used		Not used	Optional
NM107	Not Used		Not used	Optional
NM108 - p131	Identification Code Qualifier	1/2	PI – Payer Identification	HIPAA Requirement
NM109 - p131	Identification Code	2/80	DNC00 - Claims DNC00 - Medicaid Replacement/Void NCDMH - IPRS Replacement/Void When CLM05-3 = '7' or '8', the financial payer must be designated in this field. When CLM05-3 = '1', this field should contain 'DNC00'.	HIPAA Requirement
	M1*PR*2*EDS/NC DHHS*****PI*DNC00~			T
	- CLAIM INFORMATION		p to 100 times per Loop 2000B occurrence	
Claim Inform			time per Loop 2300 occurrence	Required
CLM01 - p171	Claim Submitter's Identifier	1/38	Provider's internal account number for patient.  A separate Medical Record Number field has been added – See REF segment below.	Required and Edited
CLM02 - p172	Monetary Amount	1/18	Total Claim Charge Amount	Required and Edited
CLM03	Not Used		Not used	Optional
CLM04	Not Used		Not used	Optional
CLM05 - p171	Health Care Service Location Information		Place of Service	
CLM05-1 p173	Facility Type/Place of Service Code Value	1/2	12 – Home 22 – Outpatient Hospital	Required and Edited

HIPAA FIELD - PAGE#	HIPAA FIELD NAME	FIELD LENGTH	DATA CONTENT	COMMENT
			99 – Other Unlisted Facility	
			99 – Other Offisted Facility	
			See implementation guide p173 for list of additional allowable code values.	
CLM05-2	Not Used		Not Used	Optional
CLM05-3 p173	Claim Frequency Code	1/1	<ul><li>1 – Original - Admit thru Discharge Claim</li><li>7 – Replacement - Adjustment Claim</li><li>8 – Void – Recoupment Claim</li></ul>	Required and Edited
CLM06 - p174	Yes/No Condition or Response Code	1/1	Y – Yes – Provider signature on file code	Required
CLM07 - p174	Provider Accept Assignment Code	1/1	A – Assigned	Required
CLM08 - p175	Yes/No Condition or Response Code	1/1	Y – Yes – Authorization of benefits to be assigned to the provider.	Required
CLM09 - p175	Release of Information Code	1/1	A-Appropriate Release on Information on File I-Informed Consent to Release Medical Information Regulated by Federal Statutes M-Provider has limited or restricted ability to release data N-Not allowed to release data O-On file at Payor Y-Provider has signed statement permitting release of data	Required
			**NOTE – CMS recommendation limits field to 'Y' or 'N', however, all values are compliant	
CLM10 - p177	Patient Signature Source Code	1/1	S – Signed signature authorization form for HCFA- 1500 Claim Form block 12 on file.	Required
CLM11 - p177	Related Causes Information			Situational - Required when the condition being reported is accident or employment related.

HIPAA FIELD - PAGE#	HIPAA FIELD NAME	FIELD LENGTH	DATA CONTENT	COMMENT
_				
CLM11-1	Related-Causes Code	2/3	See implementation guide p176 for requirement conditions and allowable code values.	HIPAA Requirement
			AP (Another Party Responsible) – Not mapped in MMIS+	
			AA (Auto Accident)	
			EM (Employment) – defined as On-the-Job Injury OA (Other Accident) - defined as Accidental Injury	
CLM11-2	Not Used		Not used	Optional
CLM11-3 p177	Not Used		Not used	Optional
CLM11-4 p177	State or Province Code	2/2	Enter state code in which accident occurred.	Situational - Required if CLM11- 1, -2, or -3 = AA to identify the state in which accident occurred.
Example: CL	.M*777666555*200.50***99::1*Y*A*Y*M*S*	AA:::NC~		•
Date – Initia	I Treatment	Occurs 1	time per Loop 2300 occurrence	Situational - Required for Medicaid Specialized Therapies Services
DTP01 - p183	Date/Time Qualifier	3/3	454 – Initial Treatment	HIPAA Requirement
DTP02 - p183	Date Time Period Format Qualifier	2/3	D8 – Date expressed in format CCYYMMDD	HIPAA Requirement
DTP03 - p183	Date Time Period	1/35	Initial Treatment Date	HIPAA Requirement
	P*454*D8*20001001~			
Date - Accid		Occurs 1	time per Loop 2300 occurrence	Situational - Required if CLM11- 1, CLM11-2, or CLM11-3 = AA, AB, AP, or OA.
DTP01 -	Date/Time Qualifier	3/3	439 – Accident	HIPAA Requirement

HIPAA FIELD - PAGE#	HIPAA FIELD NAME	FIELD LENGTH	DATA CONTENT	COMMENT
p194				
DTP02 - p194	Date Time Period Format Qualifier	2/3	D8 – Date expressed in format CCYYMMDD	HIPAA Requirement
DTP03 - p195	Date Time Period	1/35	Date	HIPAA Requirement
Example: DT	P*439*D8*20001001~			
	lemental Information	Occurs 1	time per Loop 2300 occurrence	Situational – Required if Medicare override needed for claim to process
PWK01 – p216	Report Type Code	2/2	OZ-Support Data for Claim	HIPAA Requirement
PWK02 – p217	Report Transmission Code	1/2	AA – Available on Request at Provider Site (This combination of values is equivalent to an F2 Stamp)	HIPAA Requirement
Example: PV	VK*OZ*AA~		- Camp)	
Example: PWK*OZ*AA~  Claim Reference Information		Occurs 1	time per Loop 2300 occurrence	Situational - Required when CLM05-3 = 7 – Replacement or 8 - Void
REF01 – p231	Reference Identification Qualifier	2/3	F8 – Original Reference Number	HIPAA Requirement
REF02 – p231	Claim Original Reference Number	1/30	Original ICN for Claim being adjusted or voided	HIPAA Requirement
Example: RE	F*F8*252003035000111~	•		
Medical Record Information			time per Loop 2300 occurrence	Required by IPRS
REF01 – p242	Reference Identification Qualifier	2/3	EA – Medical Record Identification Number	HIPAA Requirement
REF02 – p242	Medical Record Number	1/30	Client Medical Record Number	HIPAA Requirement
	F*EA*063528~			
<b>Health Care</b>	Diagnosis Code	Occurs 1	time per Loop 2300 occurrence	Required by MMIS+

HIPAA FIELD - PAGE#	HIPAA FIELD NAME	FIELD LENGTH	DATA CONTENT	COMMENT
HI01 - p266	Health Care Code Information			Required and Edited
HI01-1 p266	Code List Qualifier Code	1/3	BK – Principal Diagnosis ICD-9 Codes (primary)	
			Reason for treatment is the primary diagnosis in IPRS.	
HI01-2 p266	Industry Code	1/30	Diagnosis Code – Do not enter decimal point	
HI02 - p267	Health Care Code Information			Optional
HI02-1 p267	Code List Qualifier Code	1/3	BF - Diagnosis ICD-9 Codes (secondary)	
HI02-2 p267	Industry Code	1/30	Diagnosis Code	
HI03 - p268	Health Care Code Information			Optional
HI03-1 p268	Code List Qualifier Code	1/3	BF - Diagnosis ICD-9 Codes (third)	
HI03-2 p268	Industry Code	1/30	Diagnosis Code	
HI04 - p268	Health Care Code Information			Optional
HI04-1 p268	Code List Qualifier Code	1/3	BF - Diagnosis ICD-9 Codes (fourth)	
HI04-2 p268	Industry Code	1/30	Diagnosis Code	
HI05 - p269	Health Care Code Information		**The MMIS+ Initial HIPAA Implementation will continue to use only the first 4 diagnosis codes**	Optional
HI05-1 p269	Code List Qualifier Code	1/3	BF - Diagnosis ICD-9 Codes (fifth)	
HI05-2 p269	Industry Code	1/30	Diagnosis Code	
HI06 - p269	Health Care Code Information		**The MMIS+ Initial HIPAA Implementation will continue to use only the first 4 diagnosis codes**	Optional
HI06-1 p269	Code List Qualifier Code	1/3	BF - Diagnosis ICD-9 Codes (sixth)	
HI06-2 p269	Industry Code	1/30	Diagnosis Code	
HI07 - p270	Health Care Code Information		**The MMIS+ Initial HIPAA Implementation will continue to use only the first 4 diagnosis codes**	Optional
HI07-1 p270	Code List Qualifier Code	1/3	BF - Diagnosis ICD-9 Codes (seventh)	
HI07-2 p270	Industry Code	1/30	Diagnosis Code	
HI08 - p270	Health Care Code Information		**The MMIS+ Initial HIPAA Implementation will continue to use only the first 4 diagnosis codes**	Optional
HI08-1 p270	Code List Qualifier Code	1/3	BF - Diagnosis ICD-9 Codes (eighth)	
HI08-2 p270	Industry Code	1/30	Diagnosis Code	
	K:7834*BF:7835*BF:7836*BF:7837*BF			•

HIPAA FIELD - PAGE#	HIPAA FIELD NAME	FIELD LENGTH	DATA CONTENT	COMMENT
	A - REFERRING PROVIDER NAME	Occurs 1	time per Loop 2300 occurrence	NOTE: Claims processing will always occur against the Provider data submitted at the header level.
Referring P	rovider Name	Occurs 1	time per Loop 2310A occurrence	Required by IPRS
NM101 - p284	Entity Identifier Code	2/3	DN – Referring Provider  The referring provider is used to determine the responsible LMA, whose budget will be debited to pay for the claim.	HIPAA Requirement
NM102 - p284	Entity Type Qualifier	1/1	2 - Non-Person Entity	HIPAA Requirement
NM103 - p284	Referring Provider Last Name or Organization Name	1/35	Organization Name	HIPAA Requirement
NM104	Not Used		Not Used	
NM105	Not Used		Not Used	
NM106	Not Used		Not Used	
NM107	Not Used		Not Used	
NM108	Identification Qualification Code	<mark>1/2</mark>	24 – Employer's Identification Number if provider is atypical XX – NPI if provider is typical	HIPAA Requirement
NM109	Referring Provider Identifier	<mark>2/80</mark>	Federal Tax Number (atypical)  OR NPI Number (typical)	HIPAA Requirement
	IM1*DN*2*DUPLIN SAMPSON BILLING**: IM1*DN*2*DUPLIN SAMPSON BILLING**:			
	rovider Specialty Information		time per Loop 2310A occurrence	Optional
PRV01 - p285	Provider Code	1/3	RF - Referring	HIPAA Requirement
PRV02 - p285	Reference Identification Qualifier	2/3	ZZ – Mutually Defined Health Care Provider Taxonomy Code	HIPAA Requirement
PRV03 - p285	Reference Identification	1/30	Provider Taxonomy Code -10 digit taxonomy code for the referring provider.	HIPAA Requirement

HIPAA FIELD - PAGE#	HIPAA FIELD NAME	FIELD LENGTH	DATA CONTENT	COMMENT
			Taxonomy must comply with HIPAA  **NOTE – Taxonomy codes are updated on a periodic basis. If submitted, this value will need to be maintained to remain compliant.	
Example: Pf	RV*RF*ZZ*261QM1300X~			
Referring P	rovider Secondary Information	Occurs up	to 5 times per Loop 2310A occurrence	Situational – Required by IPRS if Referring Provider is atypical, i.e. NM108 contains 24
REF01 - p288	Reference Identification Qualifier	2/3	0B – State License Number	HIPAA Requirement
REF02 - p288	Reference Identification	1/30	IPRS Provider Number  Enter the responsible LMA's non-alpha suffix base provider number.	Required and Edited
	EF*0B*3404045~			
LOOP 2310	B - RENDERING PROVIDER NAME	Occurs 1	time per Loop 2300 occurrence	NOTE: Claims processing will always occur against the Provider data submitted at the header level.
Rendering Provider Name		Occurs 1 time per Loop 2310B occurrence		Situational – Required when Rendering Provider is Different from Billing Provider
NM101 - p291	Entity Identifier Code	2/3	82 – Rendering Provider	HIPAA Requirement
NM102 - p291	Entity Type Qualifier	1/1	1 – Person 2 - Non-Person Entity	HIPAA Requirement

HIPAA FIELD - PAGE#	HIPAA FIELD NAME	FIELD LENGTH	DATA CONTENT	COMMENT
		1	T	T.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
NM103 - p291	Name Last or Organization Name	1/35	Last Name	HIPAA Requirement
			**NOTE – If this is a hard-coded value, recommend coding 'Area Program/Contract Provider'.	
NM104 - p291	Name First	1/25	Required if NM102=1 (person)	HIPAA Requirement
NM105 - p292	Not Used		Not Used	Optional
NM106	Not Used		Not Used	Optional
NM107 - p292	Not Used		Not Used	Optional
NM108 - p292	Identification Code Qualifier	1/2	Identification Code Qualifier	HIPAA Requirement
p===			Code = 24 if NM101=82 and NM102=2 and provider	
			is atypical	
			Employer's Identification Number	
			Code = 34 if NM101=82 and NM102=1 and provider	
			is atypical	
			Social Security Number	
			Code = XX if NPI being used	
NM109 -	Identification Code	2/80	Tax ID or Social Security Number of Rendering	HIPAA Requirement
p292			Provider (atypical) OR NPI (typical)	
	M1*82*1*WELBY*MARCUS****34*333666			
	<mark>M1*82*1*WESTHEIMER*RUTH****XX*232</mark> Provider Specialty Information		time per Loop 2310B occurrence	Ontional This
-				Optional – This segment should not be submitted if the PRV segment is submitted in Loop 2000A
PRV01 - p293	Provider Code	1/3	PE – Performing	HIPAA Requirement
PRV02 - p294	Reference Identification Qualifier	2/3	ZZ – Mutually Defined	HIPAA Requirement

HIPAA FIELD - PAGE#	HIPAA FIELD NAME	FIELD LENGTH	DATA CONTENT	COMMENT
PRV03 - p294	Reference Identification	1/30	Provider Taxonomy Code -10 digit taxonomy code for the attending provider.	HIPAA Requirement
			Taxonomy must comply with HIPAA	
			**NOTE – Taxonomy codes are updated on a periodic basis. If submitted, this value will need to be maintained to remain compliant.	
	RV*PE*ZZ*103TF000N~			
Rendering I	Provider Secondary Information	Occurs up	o to 5 times per Loop 2310B occurrence	Situational – Required by IPRS when Rendering Provider is Different from Billing Provider and Rendering Provider is atypical , i.e. NM108 contains 24 or 34
REF01 - p296	Reference Identification Qualifier	2/3	0B – State License Number	HIPAA Requirement
REF02 - p296	Reference Identification	1/30	IPRS Attending Provider Number  This can be any enrolled IPRS Billing or Attending Provider number	Required and Edited
	F*0B*DS00045~			
	D SERVICE FACILITY LOCATION	Occurs 1 time per Loop 2300 occurrence		
Individual o	r Organizational Name	Occurs 1	time per Loop 2310D occurrence	
NM101 - p305	Entity Identifier Code	2/3	77 – Service Location	HIPAA Requirement
NM102 – p305	Entity Type Qualifier	1/1	2 – Non-Person Entity	HIPAA Requirement
NM103 – p305	Organization Name	1/35	Facility Name	Required
NM104	First Name			Not Used

HIPAA FIELD - PAGE#	HIPAA FIELD NAME	FIELD LENGTH	DATA CONTENT	COMMENT
NM105	Middle Name			Not Used
NM106	Name Prefix			Not Used
NM107	Name Suffix			Not Used
NM108 – p306	Identification Code Qualifier	1/2	24 – Employer Identification Number if provider is atypical 34 – Social Security Number if provider is atypical XX – NPI if provider is typical	Required
NM109 – p306	Identification Code	2/80	Tax ID or Social Security Number (atypical) OR NPI (typical) of Rendering Provider Agency	Required
Examples: NM	1*77*2*GROUP HOME NAME****24*56-1	234567~		-
	1*77*2*SERV AGENCY NAME****XX*123			
Service Facili	ty Location Address	Occurs 1	time per Loop 2310D occurrence	
N301 – p308	Address Information	1/55	Service facility address	HIPAA Requirement
	156 MAIN STREET~			
	ty Location City/State/Zip Code		time per Loop 2310D occurrence	Required
N401 – p309	City Name	2/30	Service facility location city name.	HIPAA Requirement
N402 – p310	State or Province Code	2/2	Service facility location state code.	HIPAA Requirement
N403 – p310	Postal Code	3/15	Service facility location zip code including 4-digit extension.	HIPAA Requirement
Example: N4*[	OUPLIN/SAMPSON*NC*231104321~	•		•
	ty Location Secondary Identification		time per Loop 2310D occurrence	Situational – Required by IPRS if Referring Provider is atypical, i.e. NM108 contains 24 or 34
REF01 – p311	Reference Identification Qualifier	2/3	LU – Location Number	HIPAA Requirement
REF02 – p312	Reference Identification	1/30	Enter the agency number as it is enrolled in IPRS.	Required and Edited
Example: REF	*LU*DS00001P~	•		•
LOOP 2320 O	THER SUBSCRIBER INFORMATION	Occurs up	to 10 times per Loop 2300 occurrence	

HIPAA FIELD - PAGE#	HIPAA FIELD NAME	FIELD LENGTH	DATA CONTENT	COMMENT
	criber Information	Occurs 1	time per Loop 2320 occurrence	Situational – Required when reporting TPL information
SBR01 -	Payer Responsibility Sequence Number	1/1	P – Primary	HIPAA Requirement
p320	Code			
			S-Secondary	
0000		0.0	T-Tertiary	LUDAA D
SBR02 - p320	Individual Relationship Code	2/2	18 – Self	HIPAA Requirement
SBR03 -	Reference Identification	1/30	Insured Group or Policy number	Required and Edited
p321				
SBR04	Not Used		Not used	Optional
SBR05 - p322	Insurance Type Code	1/3	See implementation guide p322 for list of allowable code values.	HIPAA Requirement
			Use code OT (other) if list does not contain appropriate code.	
SBR06	Not Used		Not Used	Optional
SBR07	Not Used		Not Used	Optional
SBR08	Not Used		Not Used	Optional
SBR09 – p322	Claim Filing Indicator Code	1/2	See implementation guide p322-323 for list of allowable code values.	Required and Edited
	BR*P*18*958625**OT****MC~		anowabic code values.	
	n of Benefits Payer Paid Amount	Occurs 1	time per Loop 2320 occurrence	Required when loop 2320 is reported
AMT01 - p332	Amount Qualifier Code	1/3	D – Payor Amount Paid	HIPAA Requirement
AMT02 - p332	Monetary Amount	1/18	Claim Amount Paid	Edited if reported
F 2 = -			This is a crosswalk from CLP04 in 835 when doing COB	

Example: AMT\*D\*25.35~

HIPAA FIELD - PAGE#	HIPAA FIELD NAME	FIELD LENGTH	DATA CONTENT	COMMENT
Subscriber D	Pemographic Information	Occurs 1	time per Loop 2320 occurrence	Situational – Required when 2330A NM102 = 1
DMG01 - p343	Date Time Period Format Qualifier	2/3	D8 – Date expressed in format CCYYMMDD	HIPAA Requirement
DMG02 - p344	Date Time Period	1/35	Subscriber Date of Birth	HIPAA Requirement
DMG03 - p344	Gender Code	1/1	F – Female M – Male U – Unknown	HIPAA Requirement
Example: DM	G*D8*19770615*F~			
Other Insura	nce Coverage Information	Occurs 1	time per Loop 2320 occurrence	Required when Loop 2320 is reported
Ol01	Not Used		Not Used	Optional
OI02	Not Used		Not Used	Optional
Ol03 - p346	Yes/No Condition or Response Code	2/2	Y – Yes - Authorize assignment of benefits to be paid directly to the provider N - No	HIPAA Requirement
OI04 - p346	Patient Signature Source Code	1/1	S – Signed signature authorization form for HCFA- 1500 Claim Form block 12 on file. Required except in cases where "N" is used in Ol06 See implementation guide p345 for list of additional	HIPAA Requirement
			code values.	
OI05	Not Used		Not Used	Optional
Ol06 - p346	Release of Information Code	1/1	M – The Provider has Limited or Restricted Ability to Release Data Related to a Claim  See implementation guide p345-346 for list of	HIPAA Requirement
			additional code values.	
Example: OI**				
LOOP ID - 23	30A OTHER SUBSCRIBER NAME	Occurs 1	time per Loop 2300 occurrence	

HIPAA FIELD -	HIPAA FIELD NAME	FIELD LENGTH	DATA CONTENT	COMMENT
PAGE#				
Other Subs	Other Subscriber Name		Occurs 1 time per Loop 2330A occurrence	
NM101 - p351	Entity Identifier Code	2/3	IL – Insured or Subscriber	reported HIPAA Requirement
NM102 - p351	Entity Type Qualifier	1/1	1 – Person	HIPAA Requirement
NM103 - p351	Name Last or Organization Name	1/35	Last name of subscriber (patient).	Required and Edited
NM104 - p351	Name First	1/25	Enter first name of subscriber (patient). Required if NM102 = 1	Required and Edited
NM105 - p351	Name Middle	1/25	Middle Initial	Optional
NM106	Not Used		Not Used	Optional
NM107 - p352	Not Used		Not Used	Optional
NM108 - p353	Identification Code Qualifier	1/2	MI – Member Identification number.	HIPAA Requirement
NM109 - p353	Identification Code	2/80	Other Subscriber Identifier	Required and Edited
Example: NI	M1*IL*1*SMITH*JANE****MI*912478911B~			
LOOP ID - 2	330B OTHER PAYER NAME	Occurs 1	time per Loop 2300 occurrence	
Other Payer	r Name	Occurs 1	time per Loop 2330B occurrence	Required when Loop 2320 is reported
NM101 - p360	Entity Identifier Code	2/3	PR – Payer	HIPAA Requirement
NM102 - p360	Entity Type Qualifier	1/1	2 – Non-Person Entity	HIPAA Requirement
NM103 - p360	Name Last or Organization Name	1/35	Enter other payer name.	HIPAA Requirement
NM104	Not Used		Not Used	Optional
NM105	Not Used		Not Used	Optional
NM106	Not Used		Not Used	Optional
NM107	Not Used		Not Used	Optional

HIPAA FIELD - PAGE#	HIPAA FIELD NAME	FIELD LENGTH	DATA CONTENT	COMMENT
		1		T
NM108 - p360	Identification Code Qualifier	1/2	PI – Payor Identification	HIPAA Requirement
NM109 - p361	Identification Code	2/80	Identification Code	HIPAA Requirement
Example: NN	/11*PR*2*MEDICARE*****PI*0000000~			·
Date Paid		Occurs 1	time per Loop 2330B occurrence	Situational - Required when Loop 2430 is not reported
DTP01 – p367	Date Time Qualifier	3/3	573 - Date Claim Paid	HIPAA Requirement
DTP02 – p367	Date Time Period Format Qualifier	2/3	D8 – Date expressed in format CCYYMMDD	HIPAA Requirement
DTP03 – p368	Adjudication or Payment Date	1/35	Paid Date	HIPAA Requirement
	P*573*D8*20030205~			
Other Payer	Secondary Identifier		o to 2 times per Loop 2330B occurrence	Situational - Required when Loop 2320 is reported and Secondary Payer Identification is needed
REF01 – p369	Reference Identification Qualifier	2/3	2U-Payer ID Number	HIPAA Requirement
pood			FY-Claim Office Number	
			NF-NAIC Code	
			TJ-Federal Taxpayer's ID Number	
			(F8-Original Ref # - Not Valid for Providers)	
REF02 – p370	Reference Identification	1/30	Other Payer Claim Reference number	Required and Edited
Example: RE	F*TJ*561020225~	•		
<b>LOOP 2400</b>	- SERVICE LINE	Occurs up	to 50 times per Loop 2300 occurrence	

HIPAA FIELD -	HIPAA FIELD NAME	FIELD LENGTH	DATA CONTENT	COMMENT
PAGE#				
				1
Service Line			time per Loop 2400 occurrence	Required
LX01 - p398	Assigned Number	1/6	Enter service line number starting with 01, incrementing by 1	HIPAA Requirement
			IPRS recommends 1 detail per claim to avoid total claim denial as a result of 1 denied detail.	
Example: LX*0	1~			
Professional S	Service	Occurs 1	time per Loop 2400 occurrence	Required
SV101 - p400	Composite Medical Procedure Identifier			
SV101-1 p401	Product/Service ID Qualifier	2/2	HC – Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes."	HIPAA Requirement
SV101-2 p402	Product/Service ID	1/48	Procedure Code	Required and Edited
SV101-3 - p402	Procedure Modifier	2/2	Procedure Code Modifier-1	Optional
SV101-4 – p402	Procedure Modifier	2/2	Procedure Code Modifier-2	Optional
SV101-5 – p403	Procedure Modifier	2/2	Procedure Code Modifier-3	Optional
SV101-6 – p403	Procedure Modifier	2/2	Procedure Code Modifier-4	Optional
SV101-7	Not Used		Not Used	Optional
SV102 - p403	Monetary Amount	1/18	Submitted charge amount including the decimal.	Required and Edited
SV103 - p404	Unit or Basis for Measurement Code	2/2	UN – Unit	HIPAA Requirement
SV104 - p404	Quantity	1/15	HCPCS/CPT codes are submitted as 1 unit per day.	Required and Edited
			IPRS-only procedures are reported in 15 minute intervals unless specified as daily in the IPRS Audits Manual:  1 unit = 15 minutes 2 units = 30 minutes etc. Units may be reported using a decimal value if	
		1	needed.	
SV105 - p405	Place of Service	1/2	Detail Place of Service	Situational – Required only when

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				different from value reported in CLM05-1
SV106 - p405	Service Type Code	1/2	No Longer stored in MMIS+	Optional
SV107 - p405	Composite Diagnosis Code Pointer		Used to identify one or more diagnosis code pointers.	Optional
SV107-1 p405	Diagnosis Code Pointer	1/2	1 - Use this pointer for the first diagnosis code pointer (primary diagnosis for this service line).	HIPAA Requirement
SV107-2	Not Used		Not Used	Optional
SV107-3	Not Used		Not Used	Optional
SV107-4	Not Used		Not Used	Optional
SV108	Not Used		Not Used	Optional
SV109 - p407	Yes/No Condition or Response Code	1/1	Y –Emergency Indicator	Situational – Required only when reporting an Emergency
Example: SV1*	*HC:YP498*20.50*UN*2*12**1**Y~			
Service Date		Occurs 1	time per Loop 2400 occurrence	Required
DTP01 - p435	Date/Time Qualifier	3/3	472 – Service	HIPAA Requirement
DTP02 - p436	Date/Time Period Format Qualifier	2/3	RD8	HIPAA Requirement
DTP03 - p436	Date Time Period	1/35	Enter date range in CCYYMMDD - CCYYMMDD format. The date range represents the from/to dates in the MMIS+ and IPRS. Entering the same date for the from/to date is also a valid entry.	Required and Edited
Example: DTP	*472*RD8*20001001-20001001~		•	
Line Item Con	trol Number	Occurs 1	time per Loop 2400 occurrence	Required by IPRS
REF01 - p472	Reference Identification Qualifier	2/3	6R – Provider Control Number	HIPAA Requirement
REF02 - p473	Reference Identification	1/30	Line Item Control Number	Required and Edited
	*6R*123456789~	•		

HIPAA FIELD - PAGE#	HIPAA FIELD NAME	FIELD LENGTH	DATA CONTENT	COMMENT
LOOP 2420A - RENDERING PROVIDER NUMBER		Occurs 1 time per Loop 2400 occurrence		NOTE: Provider information reported at the detail level is informational only in MMIS+. Claims process based on header level data only.
Rendering F	Provider Name	Occurs 1	time per Loop 2420A occurrence	Situational – Report if different from Header Rendering Provider Data
NM101 - p502	Entity Identifier Code	2/3	82 – Rendering Provider	HIPAA Requirement
NM102 - p502	Entity Type Qualifier	1/1	1 – Person 2 – Non-Person Entity	HIPAA Requirement
NM103 - p502	Name Last or Organization Name	1/35	**NOTE – If this is a hard-coded value, recommend coding 'Area Program/Contract Provider'.	HIPAA Requirement
NM104 - p502	Name First	1/25	Required if NM102=1 (person)	HIPAA Requirement
NM105 – p502	Not Used		Not Used	Optional
NM106	Not Used		Not Used	Optional
NM107 – p502	Not used		Not Used	Optional
NM108 – p502	Identification Code Qualifier	1/2	Identification Code Qualifier  Code = 24 if NM101=82 and NM102=2  Employer's Identification Number if provider is atypical  Code = 34 if NM101=82 and NM102=1	HIPAA Requirement

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NI Rendering P	Identification Code  M1*82*1*WELBY*MARCUS****34*333666998  M1*82*1*WESTHEIMER*RUTH****XX*23232  rovider Specialty Information	32328~ Occurs 1	Social Security Number if provider is atypical  Code = XX if NPI being used if provider is typical  Tax ID or Social Security (atypical) OR NPI Number (typical) of Rendering Provider.  time per Loop 2420A occurrence	HIPAA Requirement  Optional
PRV01 - p504	Provider Code	1/3	PE – Rendering	HIPAA Requirement
PRV02 - p504	Reference Identification Qualifier	2/3	ZZ – Mutually Defined	HIPAA Requirement
PRV03 - p504	Provider Taxonomy Code	1/30	Provider Taxonomy Code -10 digit taxonomy code for the attending provider.  Must Comply with HIPAA  **NOTE – Taxonomy codes are updated on a periodic basis. If submitted, this value will need to be maintained to remain compliant.	HIPAA Requirement
	V*PE*ZZ*103TF000N~ rovider Secondary Identification	Occurs up	o to 5 times per Loop 2420A occurrence	Situational – Required by IPRS when Loop 2420A is reported and attending provider is atypical, i.e. NM108 contains 24 or 34
REF01 - p507	Reference Identification Qualifier	2/3	0B – State License Number	HIPAA Requirement
REF02 - p507	Rendering Provider Secondary Identifier  F*0B*DS00025~	1/30	IPRS Attending Provider Number  This can be any enrolled IPRS Billing or Attending Provider number	Required and Edited

HIPAA FIELD - PAGE#	HIPAA FIELD NAME	FIELD LENGTH	DATA CONTENT	COMMENT
LOOP 2420F - REFERRING PROVIDER NUMBER		Occurs 1 time per Loop 2400 occurrence		NOTE: Provider information reported at the detail level is informational only in MMIS+. Claims process based on header level data only.
Referring P	rovider Name	Occurs 1	time per Loop 2420F occurrence	Situational – Report if different from Header Referring Provider Data
NM101 - p542	Entity Identifier Code	2/3	DN – Referring Provider  The referring provider is used to determine the responsible LMA, whose budget will be debited to pay for the claim.	HIPAA Requirement
NM102 - p542	Entity Type Qualifier	1/1	1 – Person	HIPAA Requirement
NM103 - p542	Name Last or Organization Name	1/35	Referring provider last name.	HIPAA Requirement
NM104 - p542	Name First	1/25	Referring provider first name.	HIPAA Requirement
NM105 - p542	Not Used		Not Used	
NM106 - p542	Not Used		Not Used	
NM107 - p542	Not Used		Not Used	
NM108 - p542	Identification Qualification Code	1/2	24 – Employer's Identification Number if provider is atypical XX – NPI if provider is typical	HIPAA Requirement
NM109 - p542	Referring Provider Identifier	2/80	Federal Tax Number (atypical) OR NPI Number (typical)	HIPAA Requirement

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	M1*DN*1*DUPLIN SAMPSON*BILLING**** M1*DN*1*SUPLIN SAMPSON*BILILNG <mark>****</mark>		~	
Referring P	rovider Specialty Information	Occurs 1	time per Loop 2420F occurrence	Optional
PRV01 - p544	Provider Code	1/3	RF – Referring	HIPAA Requirement
PRV02 - p545	Reference Identification Qualifier	2/3	ZZ – Mutually Defined Health Care Provider Taxonomy Code	HIPAA Requirement
PRV03 - p545	Reference Identification	1/30	Provider Taxonomy Code -10 digit taxonomy code for the referring provider.  Must Comply with HIPAA  **NOTE – Taxonomy codes are updated on a periodic basis. If submitted, this value will need to be maintained to remain compliant.	HIPAA Requirement
	RV*RF*ZZ*261QM1300X~ rovider Secondary Identification	Occurs up	o to 5 times per Loop 2420F occurrence	Situational – Required by IPRS when Loop 2420F is reported and the referring provider is atypical, i.e. NM108 contains 24 or 34
REF01 - p547	Reference Identification Qualifier	2/3	0B – State License Number	HIPAA Requirement
REF02 - p548	Reference Identification	1/30	Provider ID  Enter the responsible LMA's non-alpha suffix base provider number.	Required and Edited
Example: R	EF*0B*3404046~			

DATA CONTENT

FIELD

HIPAA

HIPAA FIELD NAME

COMMENT

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LOOP 2430	- LINE ADJUDICATION INFORMATION	Occurs	up to 25 times per Loop 2400 occurrence	Situational - Required when reporting TPL in LOOP 2330B for this detail
Service Line	Adjudication	Occurs	1 time per Loop 2430 occurrence	Required
SVD01 – p556	Other Payer Primary Identifier	2/80	2/80 Should match the value in NM109 of the 2330B loop for identifying Other Payer.	
SVD02 - p556	Service Line Paid Amount	1/18	TPL Detail Amount Paid	HIPAA Requirement
SVD03 – p556	Composite Medical Procedure Identifier			
SVD03-1 p556	Product/Service ID Qualifier	2/2	HC – Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes. ZZ-Mutually Defined	HIPAA Requirement
SVD03-2 p557	Product/Service ID	1/48	Procedure Code	Required and Edited
SVD03-3 p557	Procedure Modifier	2/2	Procedure Code Modifier-1	Optional
SVD03-4 p557	Procedure Modifier	2/2	Procedure Code Modifier-2	Optional
SVD03-5 p557	Procedure Modifier	2/2	Procedure Code Modifier-3	Optional
SVD03-6 p557	Procedure Modifier	2/2	Procedure Code Modifier-4	Optional
SVD03-7 p558	Not Used		Not Used	Optional
SVD04 – p558	Not Used		Not Used	Optional
SVD05 – p558	Paid Service Unit Count	1/15	HCPCS/CPT codes are submitted as 1 unit per day.  Units may be reported using a decimal value if needed.	Required and Edited
SVD06 -	Bundled Line Number	1/6	Bundled/Unbundled Line Number	Situational –

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p558				Required if payer bundled/unbundled this service line.
Example: S\	/D*0000000*20.50*HC:YP498***2~			
Line Adjust	ment Reason Information		o to 99 times per Loop 2430 occurrence	Situational - Required when TPL Amount Paid is different from TPL Amount originally Billed
CAS01 - p561	Claim Adjustment Group Code	1/2	See Implementation guide p561 for allowable code values.	HIPAA Requirement
CAS02 - p561	Claim Adjustment Reason Code - 1	1/5	Use the Claim Adjustment Reason Code List – See Implementation Guide Appendix C.	HIPAA Requirement
CAS03 - p561	Adjustment Amount - 1	1/18	Adjusted Amount	HIPAA Requirement
CAS04	Not Used		Not Used	Optional
CAS05 - p562	Claim Adjustment Reason Code - 2	1/5	Use the Claim Adjustment Reason Code List – See Implementation Guide Appendix C.	Optional
CAS06 - p562	Adjustment Amount - 2	1/18	Adjusted Amount	Optional
CAS07	Not Used		Not Used	Optional
CAS08 - p563	Claim Adjustment Reason Code - 3	1/5	Use the Claim Adjustment Reason Code List – See Implementation Guide Appendix C.	Optional
CAS09 - p563	Adjustment Amount - 3	1/18	Adjusted Amount	Optional
CAS10	Not Used		Not Used	Optional
CAS11 -	Claim Adjustment Reason Code - 4	1/5	Use the Claim Adjustment Reason Code List – See	Optional

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p564			Implementation Guide Appendix C.	
CAS12 - p564	Adjustment Amount - 4	1/18	Adjusted Amount	Optional
CAS13	Not Used		Not Used	Optional
CAS14 - p565	Claim Adjustment Reason Code - 5	1/5	Use the Claim Adjustment Reason Code List – See Implementation Guide Appendix C.	Optional
CAS15 - p565	Adjustment Amount - 5	1/18	Adjusted Amount	Optional
CAS16	Not Used		Not Used	Optional
CAS17 - p566	Claim Adjustment Reason Code - 6	1/5	Use the Claim Adjustment Reason Code List – See Implementation Guide Appendix C.	Optional
CAS18 - p566	Adjustment Amount - 6	1/18	Adjusted Amount	Optional
CAS19	Not Used		Not Used	Optional
Example: CA	\S*OA*1*20.00~		1	
Date Paid		Occurs 1 time per Loop 2430 occurrence		Required
DTP01 – p567	Date Time Qualifier	3/3	573 - Date Claim Paid	HIPAA Requirement
DTP02 – p567	Date Time Period Format Qualifier	2/3	D8 – Date expressed in format CCYYMMDD	HIPAA Requirement
DTP03 – p567	Adjudication or Payment Date	1/35	Paid Date	HIPAA Requirement
Example: DTI	P*573*D8*20030205~	•		•
TRANSACTION SET TRAILER		Occurs 1	time	Required
SE01 - p572	Number of Included Segments	1/10	Transaction Segment Count	HIPAA Requirement
SE02 - p572	Transaction Set Control Number	4/9	Transaction Set Control Number Numbers in ST02 and SE02 must be identical.	HIPAA Requirement
Example: SE'	*32*918273645~	•		·
FUNCTIONA	L GROUP TRAILER	Occurs 1	time	Required

HIPAA FIELD - PAGE#	HIPAA FIELD NAME	FIELD LENGTH	DATA CONTENT	COMMENT
		•		<u> </u>
GE	Interchange Control Header	3/3	GE	HIPAA Requirement
GE01	Number of Transaction Sets	2/2	Number of Transaction Sets (ST - SE)	HIPAA Requirement
GE02	Group Control Number	10/10	Must = GS06	HIPAA Requirement
Example of	Segment GE*1*0001~			
INTERCHANGE CONTROL TRAILER		Occurs 1 time		Required
IEA	Interchange Control Header	3/3	IEA	HIPAA Requirement
IEA01	Number of Included Functional Groups	1/5	Number of function groups (GS - GE)	HIPAA Requirement
IEA02	Interchange Control Number	9/9	Must = ISA13	HIPAA Requirement
Example of	Segment IEA*1*00000001~			